VERIFICATION OF EMPLOYMENT OF APPLICANTS FOR HEALTH FACILITY ADMINISTRATOR LICENSURE

State Form 42352 (R3 / 5-04)

*Social Security number required pursuant to IC 4-1-8-1.

Return form to:
INDIANA STATE BOARD OF
HEALTH FACILITY ADMINISTRATORS
Health Professions Bureau
402 West Washington Street, Room W066
Indianapolis, IN 46204
Telephone number: (317) 234-2051
Email address: hpb6@hpb.in.gov

**** THIS FORM IS FOR ENDORSEMENT CANDIDATES ONLY.***

APPLICANT INFORMATION		
Name (*last, first, middle, maiden*)		Social Security number*
Address (*number and street, city, state, ZIP code*)		
License number	Date of issuance*(month, day, year)*	Date of birth (*month, day, year*)
I hereby authorize _____ to furnish the Health Professions Bureau with the information below.		
Signature of applicant		Date (*month, day, year*)

THE SECTION BELOW IS TO BE COMPLETED BY THE APPLICANT'S EMPLOYER		
Name of employer		
Name of facility where employed		
Address of facility (*number and street, city, state, ZIP code*)		
Telephone number of facility ( )	Date employment began *(month, day, year)*	Date employment ended *(month, day, year)*
Position held		
Briefly describe duties of employee:		
Type of facility		Number of beds
Type of care offered		
If employee was disciplined in any way while in your employ, please provide certified copies of all related documents. Thank you for your assistance.		
I hereby swear or affirm under penalties of perjury that the information provided herein is true and correct.		
Form completed by (*signature*)	Printed name and title	
Name of firm or business		
Address of firm or business (*number and street, city, state, ZIP code*)		
Telephone number ( )	Date (*month, day, year*)	